Journal of Applied Research on Children: Informing Policy for Children at Risk

Volume 11
Issue 1 *Implementation in Real World Settings: The Untold Challenges*
Article 8

2020

Integration of Behavioral Health Services into Primary Pediatric Care: The behind the scenes story of a pilot study in Southeast, Texas

Stephanie Chapman
sgchapma@texaschildrens.org

Nancy Correa
npcorrea@texaschildrens.org

Angela Cummings
Baylor College of Medicine, angela.cummings@bcm.edu

Bethanie S. Van Horne
Baylor College of Medicine, bethanie.vanhorne@bcm.edu

Heidi Schwarzwald
schwarzwald@aetna.com

Recommended Citation

Chapman, Stephanie; Correa, Nancy; Cummings, Angela; Van Horne, Bethanie S.; and Schwarzwald, Heidi (2020) "Integration of Behavioral Health Services into Primary Pediatric Care: The behind the scenes story of a pilot study in Southeast, Texas," *Journal of Applied Research on Children: Informing Policy for Children at Risk*: Vol. 11: Iss. 1, Article 8.
DOI: https://doi.org/10.58464/2155-5834.1413
Available at: https://digitalcommons.library.tmc.edu/childrenatrisk/vol11/iss1/8

Integration of Behavioral Health Services into Primary Pediatric Care: The Behind-the-Scenes Story of a Pilot Study in Southeast Texas

INTRODUCTION

While behavioral health has been recognized for its importance in a person's overall health and well-being,[1] providing behavioral health care in the U.S. has remained a challenge. Behavioral health includes care for mental health conditions such as anxiety, attention deficit-hyperactivity disorder (ADHD), conduct disorder, depression, and post-traumatic stress disorder (PTSD); as well as substance use disorder (SUD). These are important issues to address in children particularly because most behavioral health issues begin in childhood.[2] In the short-term, children may experience challenges at home, school, and with peers,[3–9] and researchers have also found links between mental health disorders and risk-taking behaviors such as substance use and criminal behavior.[10–12] In the long term, these conditions can persist into adulthood[13] and have been associated with adverse impacts on employment, [6–9] decreased productivity, and increased substance use and injury.[14,15] However, "early detection can help parents and caregivers identify children's and adolescents' emotional or behavioral challenges and assist in getting these youths the appropriate services and support before their problems worsen and longer term consequences develop."[16]

Mental health concerns are a common pediatric condition. According to the Centers for Disease Control and Prevention (CDC), approximately 17% of 2- to 8-year-old children have a mental, behavioral, or developmental disorder.[17] The prevalence of the 4 most commonly diagnosed behavioral health conditions among children is: ADHD (9.4%),[18] anxiety (7.1%), behavioral/conduct disorder (7.4%), and depression (3.2%).[19]

In the 2016 National Survey of Children's Health, parents reported that approximately 80% of children with depression received treatment in the previous year, but only 59.3% of those with anxiety and 53.5% of those with behavioral/conduct problems received treatment.[19] Research studies have indicated that only 20-25% of children with mental health diagnoses receive treatment.[8,20,21] Under the traditional model of care, in which physical health and behavioral health conditions are treated separately, there can be many barriers to a child receiving all needed care, in particular the mental/behavioral health care needed. Barriers include stigma related to behavioral health conditions, a lack of trained

providers, long wait times, insufficient payments for providers,[22] and few pediatric behavioral health providers accepting insurance.[23]

To improve behavioral health care, the Substance Abuse and Mental Health Services Administration (SAMHSA) promotes integration of behavioral and physical health through multiple evidence-based models, including but not limited to providing behavioral health services in the primary care setting.[7] Integrating behavioral health into the pediatric primary care setting has the potential to positively impact children because most behavior health issues originate in childhood.[2] Under this model children could receive much, if not all, care needed from one practice, an approach that has been found to be the most acceptable, convenient, and effective for patients.[24]

In addition to SAMHSA's promotion of integrated care, there has been an increase in primary care clinicians screening and identifying children with emotional and behavioral disorders.[25] The American Academy of Pediatrics (AAP) also notes the pediatric primary care home as a key point of care for behavioral health issues, as pediatricians are trusted care providers and families have regular contact with pediatric providers.[26] However, at the majority of pediatric care sites, barriers remain, such as pediatricians having limited behavioral health training, time limits in the clinic day, and inadequate payment structures. Consequently, children are often referred to outside providers for treatment,[22,27] when in reality, many behavioral health issues – such as ADHD, mild depression, and anxiety – could be co-managed by a primary care provider (PCP) and a Licensed Behavioral Health Provider (LBHP) in a pediatric primary care setting.

In 2018, a team from Texas Children's Hospital and Baylor College of Medicine began a pilot study to test the feasibility and sustainability of integrating behavioral health into pediatric primary care clinics. To assist others interested in implementing similar models, this paper describes the model. The results and discussion section reports how the model was implemented across 5 pediatric practices and includes a discussion of the challenges encountered along the way. Finally, we conclude with lessons learned and recommendations for those interested in integrating behavioral health into their pediatric primary care practice. A future companion paper will describe economic and patient data outcomes of this study.

PROJECT PLAN

Behavioral health model

DOI: 10.58464/2155-5834.1413

The Texas Children's Health Plan's Center for Children and Women is a clinic located in Houston, Texas, that offers medical, dental, vision, pharmacy, speech therapy, and behavioral health services to women and children at 2 locations. Since its establishment in 2013, the Center has been offering integrated behavioral health services to its patients.

With respect to the provision of integrated behavioral health services, clinical services offered by the behavioral health team are extensive and designed to meet the majority of patients' behavioral health needs in-house. LBHPs provide crisis intervention, diagnostic assessment, medication monitoring services, and evidence-based therapy services. The most common modalities that all therapists are trained in and provide include: cognitive-behavioral therapy, dialectical behavioral therapy, interpersonal therapy, parent behavior management training, and motivational interviewing for health care adherence. Therapists also have experience in interventions for substance abuse/dependence and in marital/couples counseling. The Center LBHPs see patients for scheduled outpatient behavioral health appointments throughout the day but also have time set aside to respond to just-in-time clinic needs of patients during pediatric medical appointments. The Center LBHPs also work in close proximity to the PCPs, so that curbside consultation can occur between providers throughout the day. In terms of the Center's clinical services, traditional pediatric "mental health" needs, such as services for ADHD, depression, anxiety, and substance use, are the most dominant referral reasons, although the PCPs also refer patients for behavioral health issues such as obesity, sleep, pain management, and medical treatment adherence.

The goal of this project was to help practices hire an LBHP into their practice in order to increase access to behavioral health services and increase level of care integration. Although the project used the Center LBHP model as a guide, it was assumed that every practice would have a different goal for their level of integration and particular LBHP services provided, based on the needs of their unique clinic.

Based on data from the Center for Children and Women, we developed a model for behavioral health that suggests it should be cost-neutral or profitable for pediatric practices to hire a licensed behavioral health provider if the following 3 assumptions are met:

1. The practice has at least 3 pediatric providers, which is a commonly accepted ratio for full-time PCP to LBHP staffing on care teams.
2. The behavioral health provider will bill for 30 completed clinical encounters weekly, with an estimation that 20% of the visits would

be Diagnostic intakes (CPT code 90791), 70% of the visits a traditional therapy 45-minute encounter (CPT 90834), and 10% of the visits a health and behavioral intervention brief consultation.

3. The annual salary for the behavioral health provider is $60,000.

To test the model, the project received funding from Mental Health America of Greater Houston and the Episcopal Health Foundation. The primary research goal was to assess the feasibility of this model at 5 pediatric practices and evaluate the financial sustainability over a 1-year period. Each practice was provided funding to assist with startup costs including 2 to 3 months' salary support for the new behavioral health provider. Institutional Review Board (IRB) approval for this project was obtained from Baylor College of Medicine.

Recruiting practices

Prior to this initiative, the project research team had existing relationships with many pediatric practices in southeast Texas. Based on the team's familiarity with the practices, several were identified that the team believed would be a good fit for the pilot. These practices served a predominantly Medicaid population, had sufficient patient volume, and had either expressed a prior need for more behavioral health services or were perceived as willing to try innovative initiatives. Initially the team scheduled a meeting with the lead physician and then followed up by phone and email to gain a commitment.

Recruiting behavioral health providers

For 3 of the practices, the team provided the practice with an initial job description to help recruit the LBHP. After the practice approved the job description, the team posted the job opening on a local job board for social work graduates, on Indeed.com, and through a local listserv related to mental health. Due to lack of budget for recruiting, the project did not advertise the opportunity through professional organizations.

After candidates applied for the position, the team reviewed their resumes to ensure they had the required behavioral health licenses. Only LCSW, LPC, LFMT, and psychologists were considered for the role of LBHP as these credentials are able to bill for behavioral health services in Texas.

After an initial screen of the resume, a psychologist on the project team completed an initial phone interview. The psychologist rated a candidate's competencies in the following areas: behavioral health

services, diagnostic skills, evidence-based intervention, consultation-liaison skills with medical team providers, crisis intervention, and communication. If she thought the candidate had the necessary skills for the position, she would refer the candidate to the practice. At this point, the practices scheduled in-person interviews with the candidates to assess fit and made offers to candidates they were interested in hiring.

The remaining 2 practices were part of a large organization and differed from the other primary care practices in that they had more significant internal resources for recruitment and had other LBHPs in the system who were familiar with the qualifications and skill set required for the primary care LBHPs. As part of a larger system, the recruitment process was different in that positions were posted through the system's website, and organizational recruiters supported selection and advancement of candidates. Hiring committees utilized a semi structured organizationally designed interview process to select their candidates.

Training of LBHPs and practices

After being hired, each LBHP engaged in review of clinic procedures, review of didactic lectures, and review of treatment manuals and decision-making algorithms. Training was also provided in the form of didactic lectures for the PCPs and staff at the 5 pilot sites. The 45-minute lectures were delivered during lunch. The lectures on behavioral health interventions were delivered by the psychologist on our team. The lectures on medication management were delivered by a child psychiatrist. At the beginning of the project, the practices identified which lectures they thought would be most helpful for their medical team. The topics included: practices for behavioral health integration, medication management of pediatric depression and anxiety, medication management of ADHD and disruptive behaviors, evidence-based psychotherapy interventions for anxiety and depression, suicide assessment and intervention, and behavioral health billing and coding. The consulting psychologist also worked with practice leaders/administrators to help as needed with behavioral health template design, electronic medical record (EMR) template builds, and clinic flow processes.

Ongoing consultation

Each practice was also provided ongoing telephone consultation support from the consulting psychologist and psychiatrist working on the project. Clinic PCPs and LBHPs were able to call with clinical questions and

receive timely same-day telephone support. An average of 2 consultations occurred weekly across the practices. Consultations occurred by phone, text, and email. The goal of response time to consultation was 24 hours, although many consultations could be addressed within the hour due to the flexible nature of contact. Consultation issues were wide ranging and included family law as it relates to clinic procedures, safety assessments, diagnostic clarification, aspects of psychotherapy, medication titration questions, and social resource options in the community.

Data collection

Data collection consisted of an integration survey and medical claims data from each practice. Data to determine site-level integration was collected through a survey based on the Center for Integrated Health Solution's (CIHS) Standard Framework for Levels of Integrated Healthcare. .[28] This survey was developed using the 6 levels of integration as defined by CIHS to measure the level integration across 12 categories: facilities, communications, collaboration, meetings, roles, resources, systems/electronic medical record (EMR), treatment plans, treatment delivery, patient experience, leadership support, and provider buy-in. An overall integration score was calculated as the mean score of these 12 categories. The integration survey was administered at baseline and 6 months after the practice began integrated behavioral health care. Only one integration survey was needed for each practice, and it was completed by a team at the practice or by a high-level administrator or clinician. The follow-up survey included open-ended questions regarding perceived successes, challenges, recommendations, and advice providers would offer to others considering integrating behavioral health into their primary care practice.

Baseline integration surveys were handed out to providers at their first training, completed, and returned the same day to the trainers or scanned and emailed back later. Six-month follow-up surveys were completed by phone or electronically, depending on the clinic's preference.

To analyze patient billing and clinical care, medical claims data were requested 6 months after the LBHP started. Requested behavioral health claims data included: patient identifier, date of service, patient age or date of birth, diagnosis code(s), Current Procedural Terminology (CPT) codes, billing amount, and paid amount. The results of any behavioral health screenings provided to patients were also requested. This data is not presented as collection is ongoing and is outside the scope of this

paper. However, preliminary review of this data helped to inform the implementation described below.

DISCUSSION OF CHALLENGES

As expected in community studies, particularly those in the pilot phase, the project team had to adjust our implementation plan for both anticipated and unforeseen challenges. The following section discusses implementation results of our pilot, including challenges experienced. Data presented in this section comprise a qualitative reflection of the experiences of the project implementation team. Themes were identified by these authors after a review of preliminary quantitative clinic data and the written feedback describing the experience of the providers.

Selecting practices

While many pediatric practices expressed initial interest and a desire to integrate behavioral health into their practices, it was challenging to find practices to commit to participate in this project. Several of the practices that were initially approached to participate declined due to concerns that the practice did not have the capacity to take on a new initiative due to moving into a new building, recovery from damages from Hurricane Harvey, and/or inability to get approval from organizational leadership (for 2 practices that were part of a network of pediatric practices). Some of the practices also expressed concern about the financial risk of adding a behavioral health provider. Ultimately 9 practices were approached in order to receive commitments from 5 practices to participate.

The practices were somewhat diverse in composition, reflecting the variety of pediatric practices in the community. Practice A is a private pediatric practice in a Houston suburb with 3 pediatricians and 1 nurse practitioner. Practice B is a large private pediatric practice in Houston with 5 pediatricians and 3 nurse practitioners. Practice C is a nonprofit community clinic in rural Texas with 2 pediatricians and 1 nurse practitioner. Practice C is part of a community center that also provides a food pantry, clothes closet, and dental services. Practice D is part of a large network of pediatric practices, is located in Houston, and has 3 pediatricians. Practice E is part of a teaching hospital in which medical residents' complete rotations as part of their medical education with support from 11 pediatric faculty. All practices serve predominantly Medicaid patients. Data on racial/ethnic and linguistic demographics of the

patients served in these practices is not available. All practices were relatively advanced in their screening and identification of behavioral health needs. All practices utilized at least some form of a standardized or evidence-based behavioral health screening tool at well child visits and already had a formalized referral process for their behavioral health patients.

Recruitment of behavioral health provider

It was difficult to recruit and hire qualified LBHPs for this project, and on average it took 5.75 months to hire a qualified candidate for practices A, B, C, and E. Hiring data for practice D was not available (see rationale below). In addition, some of the practices were unable to hire a candidate that had all of the qualifications originally requested, such as being bilingual (English/Spanish) and experience in a medical practice.

Practice A: Twenty-eight initial interviews for practices A and B combined were conducted, 3 applicants were referred to practice A, and practice A interviewed all 3 applicants. It took 6 months for Practice A to hire a bilingual LBHP.

Practice B: After 5 months of unsuccessfully trying to hire a bilingual LBHP provider, practice B began interviewing English-only candidates. An English-only provider was hired 2 months later. In total, 28 initial interviews for Practice A and B combined were conducted and 7 applicants were referred to Practice B. Practice B interviewed 3 of the 7 candidates. However, 1 month after a candidate accepted the position, he informed the practice that he had accepted another position. During the recruiting process, Practice B had hired a nurse practitioner who also had a master's degree in counseling. After consultation with the project team as well as confirming that the nurse practitioner could provide and bill for behavioral health services, Practice B decided to reallocate 20% to 30% of the nurse practitioner's time to behavioral health. Because the LBHP speaks English only, Spanish-speaking patients needing behavioral health services are referred out of the practice at this time.

Practice C: The project conducted 2 initial interviews for Practice C and referred 1 candidate to the practice. It took 2 months for Practice C to hire a bilingual LBHP. This was unexpected as Practice C is in a rural area and the project team was most concerned about being able to recruit a qualified behavioral health provider there. However, these concerns may have helped the practice act quickly when presented with a strong candidate. In addition, based on the patient volume at Practice C, they

elected to hire an LBHP with 50% of her time devoted to behavioral health and 50% devoted to another grant-funded project.

Practice D: Prior to participation in this project, Practice D had a LBHP on its staff. However, the LBHP was not providing behavioral health services and was assisting patients and patient families with social needs and resources. Practice D asked the LBHP on site if she would be interested in the new role and the LBHP agreed. This LBHP is not bilingual, but the practice has a contract for telephone translation services available for patient care.

Practice E: It took 8 months for Practice E to hire a candidate. Practice E is part of a large system, and initially few qualified candidates applied for the position. It is unknown if there was little interest in this position or if qualified candidates were accidentally being screened out by human resources. Practice E interviewed 2 candidates. Seven months after recruitment began, practice E hired an English-only LBHP and used a language service to assist with non-English-speaking clients.

As described above, identification and recruitment of behavioral health providers for the pediatric practices was challenging for a variety of reasons. For this pilot, it was challenging to recruit qualified LBHPs. The ideal candidate for this position was a bilingual LBHP with experience in the medical setting. In terms of clinical skills, the LBHPs were assessed on a rubric on their generalist experience in the following elements of clinical care: diagnostic assessment and treatment planning, consultation/liaison skills, crisis intervention, psychopharmacology experience, and social work resourcing abilities. The LBHPs were also assessed on their ability to implement the following key generalist and transdiagnostic psychotherapy interventions: i) parent management training for disruptive behaviors, ii) cognitive behavioral therapy (CBT) for anxiety/depression and anger management, and iii) trauma-focused CBT for trauma survivors. Experience in medical settings and bilingual abilities were strongly desired by the practices as well.

A provider at one site noted:

> *There is a wide range of behavioral health needs in a general pediatric practice, so the LBHP needs a breadth of training that may not be usual. For instance: behavior problems in typically developing toddlers and not typically developing children and adolescents (autism, intellectual disorders), trauma-informed care, loss and grief, ADHD, school failure, substance abuse, depression/anxiety/suicidality. Give consideration of the most common behavioral health conditions seen in practice when hiring [the] LBHP.*

Additional barriers to hiring the LBHP included a competitive job market and lack of LBHP familiarity with primary care settings. Multiple times in hiring, qualified candidates became unavailable quickly as they accepted offers with other agencies. Additionally, several candidates expressed concern about the job stability of working as the only LBHP in a small private practice (as compared to working for established health care organizations) and cited this as a reason to choose alternative positions.

Meeting the Comprehensive Training Needs of the Clinics

One of the greatest rewards for the project team was working with the practices and LBHPs and providing training in new skill areas around behavioral health integration. That said, multiple challenges were encountered when rolling out the training program. In terms of the LBHPs, it was difficult to find clinicians who had the broad generalist pediatric skill set of extensive pediatric experience, skills in multiple therapeutic interventions, knowledge of psychopharmacology, and an understanding of primary care integration practices. Feedback from the behavioral health providers was that they could have used additional observation and experiential training, such as extra days observing an integrated clinic or being able to shadow the consulting psychologist in integrated care.

Within our model, didactic trainings were offered on topics the practice decided it needed. On average the practices received 4 didactic lectures. Although we provided some didactic lecture training on psychopharmacology for the medical providers, feedback from many of the medical providers was that they needed additional support before feeling comfortable taking on new areas of practice such as selective serotonin reuptake inhibitors management or ADHD stimulant medication management. A third training challenge was finding time with practice administrative staff to work out and develop processes for the LBHP credentialing, patient visit flows, and LBHP billing practices. Practices commented that “staff will need to be trained regarding scheduling and checking in patients for mental health providers,” and there needs to be “fine-tuning of schedule templates for best fit for provider and mix of patient encounters.”

Ongoing psychiatric/psychological consultation services were also available to the providers of the participating practices for the first 6 months of project implementation. With this service, the providers had direct office or cell phone lines of the consulting psychiatrist and psychologist working on this project. Providers were encouraged to reach out with calls when needed; we defined a response time expectation of 24

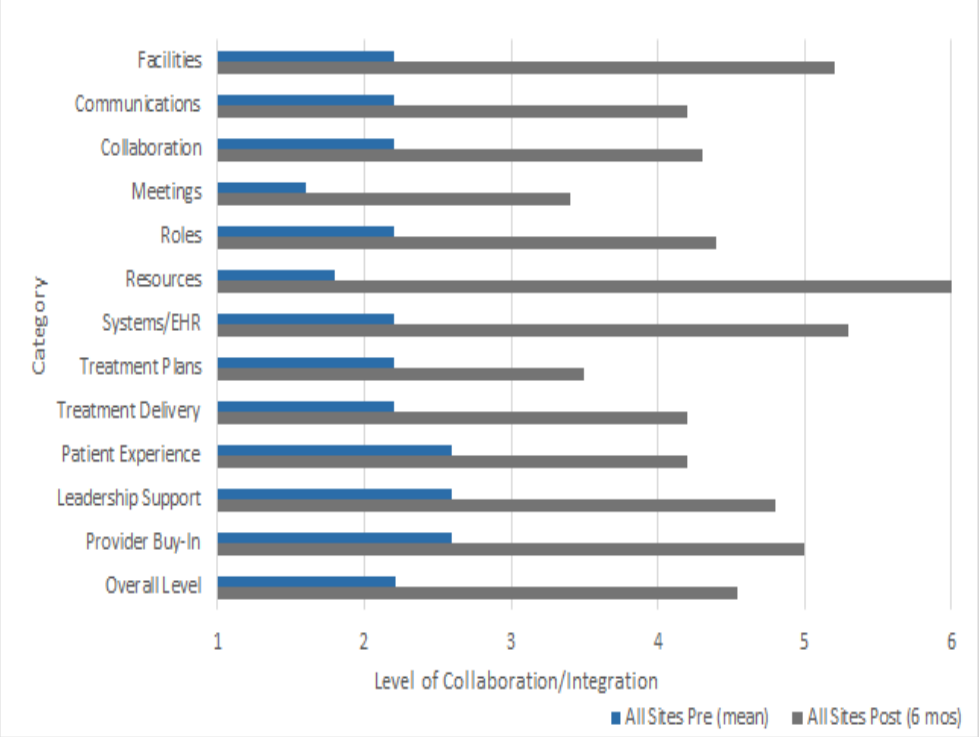
hours on weekdays. In general, consultations took 10 minutes or less. They were wide ranging in terms of clinical need, with categories including i) billing information, ii) diagnostic clarification, iii) psychotherapy recommendations, iv) social resource support, v) medication titration questions, and vi) ethical and legal concerns.

Varying Reports of Integration Achieved

Each practice completed the integration survey at baseline and at 6 months post-implementation of the integrated behavioral health model. Providers worked together or an administrative leader completed the assessment for each clinic. They rated themselves on a scale of 1 to 6 for each category. Levels 1 and 2 correspond to *coordinated care* (Level 1: Minimal Collaboration; Level 2: Basic Collaboration at a Distance), Levels 3 and 4 correspond to *co-located care* (Level 3: Basic Collaboration Onsite; Level 4: Close Collaboration Onsite with Some System Integration), and Levels 5 and 6 correspond to *integrated care* (Level 5: Close Collaboration Approaching an Integrated Practice; Level 6: Full Collaboration in a Transformed/Merged Integrated Practice).

Scores from all categories are averaged to obtain an overall level of collaboration/integration (Figure 1). While there was an increase in all categories, the greatest increase was in the sharing of resources category, where the average score for all sites increased from 1.8 to 6. Levels 1 and 2 for resources are described as “No sharing of resources” and “May share resources for single projects,” respectively. Level 6 is described as “Resources shared and allocated across whole practice.” The category with the smallest increase was that of treatment plans where the average level before BH integration was 2.2 and post was 3.5. Treatment plan Level 2 is described as “Separate treatment plans shared based on established relationships between specific providers, Level 3 means “Separate treatment plans with some shared information,” and Level 4 indicates “Collaborative treatment planning for specific patients.”

Figure 1. Pre/Post Level of Collaboration/Integration



The results indicate an overall shift from *coordinated care* to a higher level of *co-located care*, with some clinics approaching *integrated care.* The range in scores overall and for each category reflects the idiosyncratic nature of the different practices. Some practices only wanted co-located care, but others wanted a more integrated model with just-in-time behavioral health consultations during physical health visits. Some of the differences among sites included:

- Allocation of ~20% of one full-time provider (nurse practitioner) to deliver behavioral health services instead of a full-time provider. This was done to minimize lost revenue due to a shift away from well and “sick” child visits, which are reimbursed at a higher level than behavioral health services.
- Co-location of care due to the perception that same-day physical and behavioral health services would not be reimbursed.
- Starting with depression only, not full spectrum of behavioral health care; thus, the behavioral health provider was still doing a lot of “social work” consultation and referral to resources.
- Restriction of access to EMR for behavioral health provider.

- Level of administrative support (e.g., front desk support, medical assistant support) that practices wished to assign to the behavioral health provider.

Medical Claims and Billing Information

Data collection proved to be challenging. Ultimately, we were not able to collect data in the same manner across sites as all data were not available from all practices. Two practices provided claims data through onsite administrative staff, 2 others provided data through a centralized data administrator, and at the other practice the behavioral health provider maintained a log of services provided. Some sites were able to provide the amount billed but not necessarily the amount actually paid; other sites were not able to provide billing data. Non-claims-related data requested from EMR systems, such as screening results, were generally not available from the practices, as this data was generally not tracked in the EMR in a way to allow for aggregate data pulls.

Differences in Medical and Behavioral Health Cultures

One subtle but important stressor for practices during this integration process was in navigating the differences in medical and behavioral health cultures. These stressors appeared in varied ways but generally related to themes of differences in i) no-show rates, ii) LBHP space/office needs, iii) building trust between providers, and iv) LBHP efficiency development for primary care work.

For practices, one theme was understanding that there is typically a higher no-show rate for behavioral health compared to traditional pediatric appointments. Practices implemented multiple strategies to adapt to no-show rates, such as template overbooking and making the LBHP available for medical just-in-time consultations during patient no-shows.

Another theme was in understanding the LBHP provider's need for a room with comforts such as a rug and toys. Given that a high proportion of all LBHP visits were traditional 30- to 45-minute therapy interventions, all practices moved to providing the LBHP with a small office furnished with toys, comfortable seating, and play space for children during the visits. LBHP providers generally also had a portable box of small toys and creative materials that they brought with them into medical consultations in the pediatric suite.

Medical providers needed time to build trust in the LBHP provider before they transferred elements of their patient care to them. To address

this, the LBHPs were encouraged to spend as much time in the medical pods as possible and to make an effort to provide warm handoffs and regular updates of all clinical care to the PCP.

For some of the LBHP providers, it was generally a shift for them to learn to work within the busy pace of the medical practices and to reduce their charting to manageable and practical documentation for the primary care setting. Some of the LBHP providers also had to learn how to bill for elements of their care as most had come from positions in which they did not have to bill for their services. One practice noted that "adapting the EMR was a challenge because of a combination of our practice being experienced enough to create templates suitable to behavioral health and our behavioral health provider having no previous experience with our EMR." To help with this, the practices streamlined templates to reduce charting burden for the LBHPs and ensured that all LBHPs had access to a workstation to chart during the clinical encounter. Additionally, training in efficient charting was an element of the psychologist consultation.

Credentialing Difficulties

The credentialing process is very important because it dictates how practices are paid for behavioral health services delivered to their patients. For behavioral health providers to be credentialed and their services reimbursable, they must be credentialed with each payor with whom the practice is contracted, both public and private. To be credentialed through Medicaid, the licensed provider must register to obtain a Medicaid identification (ID) number. Once they have a Medicaid ID number, they must get credentialed with each Medicaid managed care organization (MCO) individually. For MCOs that contract with behavioral health organizations (BHOs), the behavioral health provider must be credentialed through the contracted BHO and not the MCO itself.

The credentialing process was a challenge for multiple sites as it can be time consuming, especially for already busy office staff. In one case, a practice experienced additional delay because they went through the credentialing process with the MCO, only to learn they should have contacted the BHO directly. The Texas Medicaid Uniformed Managed Care Contract requires MCOs to "complete the credentialing process for a new provider...no later than 90 days after receipt of a complete application." The practices had many issues with credentialing and one provider noted credentialing to be among "the most significant challenges we have encountered in this whole process." Because the credentialing process is not guaranteed to be completed in 90 days, practices were

hesitant to schedule behavioral health appointments for patients if the provider was not already credentialed with their MCO/BHO. Ultimately, this practice limited the scope of their behavioral health services to include patients from MCOs with whom the provider was already credentialed (not in the process of becoming credentialed).

Another practice used other grant funds to help cover the cost of their behavioral health provider due to a short-staffed administrative team who could not dedicate time to credentialing until more staff were hired.

Larger practices with more administrative support or those using providers who were already credentialed seemed to struggle less with credentialing, but it was still a time-consuming process; practices with smaller administrative staffs identified credentialing as the greatest challenge they faced with behavioral health integration.

Reimbursement

In addition to issues with credentialing creating delays in reimbursement for services, several of the participating practices had high proportions of their behavioral health claims initially rejected for payment. For example, in the first few months of offering behavioral health, one of our practices had a quarter of their behavioral health claims initially rejected by payors.

Additionally, because the pilot practices had generally not been billing for behavioral health services, it became increasingly evident that the project training needed to provide more information to administrative staff on billing for behavioral health services. Because there are many rules physician offices need to comply with in order to get reimbursed for services, routine check-ins with administrative staff are needed to quickly address questions and concerns about the billing process. In the pilot, the research team was not able to fully implement these check-ins as issues with credentialing delayed billing for many of our practices and the administrative staff did not often have the administrative time to provide timely and accurate data regarding claims denials.

Meeting Productivity Targets

The project modeled that within 4 months LBHPs would be up to full productivity in terms of patient volumes completed weekly. All of the practices had trouble meeting this target for a variety of reasons. Delays in credentialing were a primary reason. One practice noted, “Regarding credentialing, from the very beginning we have missed out on a lot of financial opportunities due to the length of time it takes to get a new

provider credentialed." Practices also reported lower than anticipated patient volumes, and it took additional time to build patient volume. Finally, practices also limited the scope of their LBHP providers. In one practice it was decided that the LBHP would not see patients on the same day as PCP visits, due to fear that the "same-day" services would not be reimbursed. In another practice it was decided that the LBHP would initially start by only providing services for depression, with the goal of limiting initial scope of service to ensure quality of care.

The practices utilized multiple solutions to help their LBHP providers meet productivity goals. First, they worked to get support in credentialing their providers. Practices also increased patient flow by reducing template scheduled times from 60-minute to 45-minute slots. Another solution was to develop lists of potential behavioral health patients to reach out to and bring into clinic. For example, one practice was able to utilize its EMR to pull all patients with a behavioral health diagnosis seen in the practice by the PCPs in the last calendar year. Practices also worked to increase their patients seen without appointments in the medical clinics for just-in-time consultations.

RECOMMENDATIONS AND CONCLUSIONS

While this paper focuses on the implementation challenges of integrating behavioral health into pediatric practices, there were many things that went well and overall we would consider this pilot project a success. All 5 of the pilot sites have added behavioral health services to their practices, are being reimbursed for behavioral health services, and are continuing to offer behavioral health beyond the pilot period. Every site invested substantial time and resources into this project, and we believe that some of the factors that led to this success included:

- Assisting practices in identifying qualified behavioral health providers as many of the practices did not have this expertise
- Having a psychologist onsite at the practices to help with the transition to behavioral health
- Providing assistance to not only the clinical staff but also the office staff
- Having a psychologist and psychiatrist available for same-day consultations to support the providers

All of the practices and providers also patiently worked through anticipated and unanticipated challenges. Many challenges that were encountered centered around the fact that every step took more time than expected, including recruitment of practices and providers, credentialing of

the LBHP, training of the practices and providers, and getting practices up to full behavioral health patient volume. To address the long lag time in credentialing, the recommendation is that LBHP providers be Medicaid-credentialed before they are hired, and/or once a LBHP is hired, delay the start date for 2 to 3 months to ensure the providers are credentialed with all the payors before beginning work. Of course, this may not be practical in a competitive labor market where LBHPs do not wish to contract so far out. Furthermore, the model budgeted that the practices would be fully reimbursed for their investment in the behavioral health provider and making a small profit before the first year ended; given experiences gained, it is recommended that practices budget longer prior to expectation of financial profit.

Preparation

In addition to allowing for more time, more could be done upfront to prepare the practices and the behavioral health provider. First, given the challenges in hiring bilingual LBHPs, practices that serve non-English-speaking families should consider having language services available to help in communicating with these families. However, using translation services can be expensive and make appointments run longer, which must also be considered. Furthermore, given the shortage of behavioral health providers, especially bilingual ones, practices may want to consider allocating higher salaries than the current market to expedite hiring and to attract strong candidates.

The research team also believes that more could have been done to prepare the behavioral health provider and the practice for the cultural and practice differences in behavioral health and traditional pediatric care. For example, a formal assessment of the individual needs of the practices and their goals for the LBHP provider is recommended. It would be helpful for the consulting team to provide a variety of models of LBHP integration for the practice to consider (e.g., co-located mental health vs integrated health consultation), and to also help practices rank the primary goals for the integration (e.g., increasing revenue, providing more holistic care to their patients, reducing PCP time in behavioral health counseling, etc.). In this regard, a clear, up-front discussion of practice preferences is recommended, with provision of tips for merging behavioral health and medical cultures. It is also recommended that practices establish a structured check-in to assess integration practices and difficulties on a regular basis.

Training and Implementation

The model provided the 5 sites with a consulting psychologist and psychiatrist. These providers were paramount to the success of this project, and it would have been difficult, if not impossible, to integrate behavioral health into the practice without their expertise. In addition to offering training, the consulting psychologist and psychiatrist were available for consultation from the practices on medication management, behavioral health support, and billing questions. On average, the consulting psychologist and psychiatrist received 2 calls per week and these calls helped the practices transition from offering traditional pediatric care to integrated behavioral health. In the future, it is recommended that practices plan on provision of additional training for all team members. For example, PCP provider training could have been doubled from 4 to 5 hours to 8 to 10 hours of didactic lecture and case problem solving in order to help providers feel more informed on medication management of pediatric behavioral health disorders. The LBHPs would have benefitted from more time both observing already integrated behavioral health clinics and having the consulting psychologist shadow them on the clinic floor at their respective practices. We also would recommend having the administrative support staff attend more of the training sessions, even those discussing clinical issues, so that they could better understand patient flow issues and collaborate in development of the right clinic processes. A final recommendation on the training is that the ongoing telephone clinical consultation was an important part of starting up an integrated clinic, and we would recommend that this be maintained beyond the 6 months of this project to at least 1 calendar year.

While a success of the project is that behavioral health integration continues at all 5 pilot sites beyond the project, many lessons were learned throughout the project. Recommendations for practices that are interested in integrating behavioral health include the following:

- Ensure the practice has the patient volume and enough behavioral health needs to justify an integrated behavioral health provider.
- Ensure that the pediatric providers are open to prescribing medications for behavioral health issues, with the proper training and support.
- If a practice wants to hire quickly, consider offering more than current market salaries as it took, on average, 5.75 months for our practices to hire qualified LBHPs. Additionally, have a recruiting budget so the position can be posted more widely.

- If possible, once a provider is hired, delay the start date to allow time to credential the provider before the provider begins. A delay of 2 to 3 months is ideal, but that may not always be feasible.
- If possible, form a partnership with a psychologist and psychiatrist who can help train and provide consultations for the pediatric practice throughout the first year of implementation.
- Provide training for all staff, including the office staff, to help with workflow and billing.
- Ensure that the front office staff has the necessary time and experience to credential the behavioral health provider and to manage claims that are rejected.
- Create a meeting time for the behavioral health provider and the pediatric practice to discuss implementation challenges and work through cultural differences and expectations.
- Despite the challenges encountered across the practices, providers all agreed that integrated behavioral health was a benefit to their patients. Direct quotes from practice team members illustrate these perceptions:
  "For patients and families, the convenience and potential for real-time care is critical."
  "It is beneficial to all to be under the same roof to improve communication among providers."
  "...better compliance and support. Overall, better patient care and ability to monitor patients better."
  "Many families utilize our mental health care provider and are very happy with the help provided. It helps them from traveling further away from their home for mental health care. Some even come on [the] same day for both medical and mental needs. Overall, better patient care, in that medical [and] counseling providers are able to follow and review each other's notes."
  "We saw a significant decrease in the number of referrals to outside providers. When patient care can be tackled from multiple specialties in one location, it makes it easier to provide the patients with the care that they need. Our patient satisfaction has gone up considerable amounts due to the convenience that's provided when patients do not have to go to multiple locations for their medical needs."

Integrating behavioral health into pediatric practices provides an opportunity to more readily address the behavioral health needs of the pediatric population. While integrating behavioral health into pediatric

practices can be challenging, it is greatly needed and manageable with appropriate training, time, and resources.

References

1. Perou R, Bitsko RH, Blumberg SJ, et al. Mental health surveillance among children--United States, 2005–2011. *MMWR*. 2013;62(suppl 2):1-35. https://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm?s_cid=su6202a1_w . Accessed September 29, 2020.

2. Murphey D, Stratford B, Gooze R, et al. *Are the Children Well?* Robert Wood Johnson Foundation. https://www.rwjf.org/en/library/research/2014/07/are-the-children-well-.html. Published July 8, 2014. Accessed September 29, 2020.

3. Kessler RC, Foster CL, Saunders WB, Stang PE. Social consequences of psychiatric disorders, I: educational attainment. *Am J Psychiatry*. 1995;152(7):1026-1032.

4. Lewinsohn PM, Rohde P, Seeley JR. Major depressive disorder in older adolescents: prevalence, risk factors, and clinical implications. *Clin Psychol Rev*. 1998;18(7):765-794. doi: 10.1016/S0272-7358(98)00010-5

5. Schieve LA, Boulet SL, Kogan MD, et al. Parenting aggravation and autism spectrum disorders: 2007 National Survey of Children's Health. *Disabil Health J*. 2011;4(3):143-152. doi: 10.1016/j.dhjo.2010.09.002

6. Merikangas KR, Ames M, Cui L, et al. The impact of comorbidity of mental and physical conditions on role disability in the US adult household population. *Arch Gen Psychiatry*. 2007;64(10):1180-1188. doi: 10.1001/archpsyc.64.10.1180

7. Pascoe JM, Wood DL, Duffee JH, Kuo A; American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health and Council on Community Pediatrics. Mediators and adverse effects of child poverty in the United States. *Pediatrics*. 2016;137(4):e20160340. doi: 10.1542/peds.2016-0340

8. Yogman MW, Betjemann S, Sagaser A, Brecher L. Integrated behavioral health care in pediatric primary care: a quality improvement project. *Clin Pediatr (Phila)*. 2018;57(4):461-470. doi: 10.1177/0009922817730344

9. Office of the Surgeon General; Center for Mental Health Services; National Institute of Mental Health. *Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2001. PMID: 20669516.

10. Copeland WE, Miller-Johnson S, Keeler G, Angold A, Costello EJ. Childhood psychiatric disorders and young adult crime: a prospective, population-based study. *Am J Psychiatry*. 2007;164(11):1668-1675. doi: 10.1176/appi.ajp.2007.06122026

11. Lehrer JA, Shrier LA, Gortmaker S, Buka S. Depressive symptoms as a longitudinal predictor of sexual risk behaviors among US middle and high school students. *Pediatrics*. 2006;118(1):189-200. doi: 10.1542/peds.2005-1320

12. Substance Abuse and Mental Health Services Administration. *Major Depressive Episode among Youths Aged 12 to 17 in the United States: 2004 to 2006. The NSDUH Report.* Rockville, MD; Office of Applied Studies; 2008.

13. O'Connell ME, Boat T, Warner KE, eds. *Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities*. Washington, DC: National Academies Press; 2009.

14. Centers for Disease Control and Prevention. *Mental Illness Surveillance Among Adults in the United States. MMWR.* 2011;60(suppl). https://www.cdc.gov/MMWR/pdf/other/su6003.pdf. Accessed September 29, 2020.

15. Smit F, Cuijpers P, Oostenbrink J, Batelaan N, de Graaf R, Beekman A. Costs of nine common mental disorders: implications for curative and preventive psychiatry. *J Ment Health Policy Econ*. 2006;9(4):193-200.

16. Substance Abuse and Mental Health Services Administration. *Identifying Mental Health and Substance Use Problems of Children and Adolescents: A Guide for Child-Serving Organizations*. HHS Publication No. SMA 12-4670. Rockville, MD: US Dept of Health and Human Services; 2011.

17. Centers for Disease Control and Prevention. Data and statistics on children's mental health. https://www.cdc.gov/childrensmentalhealth/data.html. Accessed September 29, 2020.

18. Danielson ML, Bitsko RH, Ghandour RM, Holbrook JR, Kogan MD, Blumberg SJ. Prevalence of parent-reported ADHD diagnosis and associated treatment among U.S. children and adolescents, 2016. *J Clin Child Adolesc Psychol*. 2018;47(2):199-212. doi: 10.1080/15374416.2017.1417860

19. Ghandour RM, Sherman LJ, Vladutiu CJ, et al. Prevalence and treatment of depression, anxiety, and conduct problems in US children. *J Pediatr*. 2019;206:256-267.e3. doi: 10.1016/j.jpeds.2018.09.021

20. Eapen V, Jairam R. Integration of child mental health services to primary care: challenges and opportunities. *Ment Health Fam Med*. 2009;6(1):43-48.

21. Halfon N, Houtrow A, Larson K, Newacheck PW. The changing landscape of disability in childhood. *Future Child*. 2012;22(1):13-42.

22. Benzer JK, Beehler S, Miller C, et al. Grounded theory of barriers and facilitators to mandated implementation of mental health care in the primary care setting. *Depress Res Treat*. 2012;2012:1-11. doi: 10.1155/2012/597157

23. Bishop TF, Press MJ, Keyhani S, Pincus HA. Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA Psychiatry*. 2014;71(2):176-181. doi: 10.1001/jamapsychiatry.2013.2862

24. Lopez M, Coleman-Beattie B, Jahnke L, Sanchez K. *Connecting Body and Mind: A Resource Guide to Integrated Health Care in Texas and the United States.* Austin, TX: Hogg Foundation for Mental Health; 2008. https://utw10282.utweb.utexas.edu/wp-content/uploads/2015/09/Connecting-Body-and-Mind.pdf. Accessed September 29, 2020.

25. American Academy of Pediatrics. Mental health initiatives. https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Pages/About-Us.aspx. Accessed September 29, 2020.

26. Leslie LK, Mehus CJ, Hawkins JD, et al. Primary health care: potential home for family-focused preventive interventions. *Am J Prev Med*. 2016;51(4)(suppl 2):S106-S118. doi: 10.1016/j.amepre.2016.05.014

27. Horwitz SM, Storfer-Isser A, Kerker BD, et al. Barriers to the identification and management of psychosocial problems: changes from 2004 to 2013. Acad Pediatr. 2015;15(6):613-620.

28. Heath, B., Wise-Romero, P., & Reynolds, K. A. (March, 2013). Standard Framework for Levels of Integrated Healthcare. Washington, D.C., SAMHSA-HRSA Center for Integrated Health Solutions.